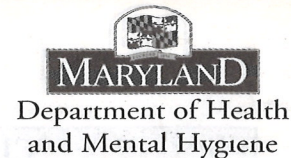


**STATE LAB
Use Only**

Laboratories Administration MD DHMH
1770 Ashland Ave. • Baltimore, MD 21205
443-681-3800 <http://dhmh.maryland.gov/laboratories/>
Robert A. Myers, Ph.D., Director
INFECTIOUS AGENTS: CULTURE/DETECTION



TYPE OR PRINT REQUIRED INFORMATION OR PLACE LABELS ON ALL THREE COPIES	<input type="checkbox"/> EH <input type="checkbox"/> FP <input type="checkbox"/> MTY/PN <input type="checkbox"/> NOD <input type="checkbox"/> STD <input type="checkbox"/> TB <input type="checkbox"/> CD <input type="checkbox"/> COR		Patient SS# (last 4 digits):	
	Health Care Provider		Last Name <input type="checkbox"/> SR <input type="checkbox"/> JR <input type="checkbox"/> Other	
	Address		First Name M.I.	
	City	County	Date of Birth (mm/dd/yyyy) / /	
	State	Zip Code	Address	
	Contact Name:		City County	
	Phone#	Fax#	State Zip Code	
	Test Request Authorized by:			
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender M to F <input type="checkbox"/> Transgender F to M		Ethnicity: Hispanic or Latino Origin? <input type="checkbox"/> yes <input type="checkbox"/> no	
	Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/other Pacific Islander <input type="checkbox"/> White			
MRN/Case #	DOC #	Outbreak #	Submitter Lab #	
Date Collected:	Time Collected:	<input type="checkbox"/> am <input type="checkbox"/> pm	Onset Date:	
Reason for Test: <input type="checkbox"/> Screening <input type="checkbox"/> Diagnosis <input type="checkbox"/> Contact <input type="checkbox"/> Test of Cure <input type="checkbox"/> 2-3 Months Post Rx <input type="checkbox"/> Suspected Carrier <input type="checkbox"/> Isolate for ID <input type="checkbox"/> Release				
Therapy/Drug Treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes Therapy/Drug Type: Therapy/Drug Date:				

↓ SPECIMEN SOURCE CODE	↓ SPECIMEN SOURCE CODE	↓ SPECIMEN SOURCE CODE
BACTERIOLOGY	MYCOBACTERIOLOGY/AFB/TB	SPECIAL BACTERIOLOGY
Bacterial Culture - Routine	AFB/TB Culture and Smear	Legionella Culture
Additional specimen codes: _____	AFB/TB Referred isolate for ID	Leptospira
<i>Bordetella pertussis</i>	<i>M. tuberculosis</i> Referred Culture for Genotyping	Mycoplasma (Outbreak Investigation Only)
Group A Strep	Nucleic Acid Amplification Test for	RESTRICTED TESTS Pre-approved submitters only
Group B Strep Screen	<i>M. tuberculosis</i> Complex (GeneXpert)	<i>Chlamydia trachomatis</i> /GC NAAT
<i>C. difficile</i> Toxin	PARASITOLOGY	Norovirus ** (see comment on back)
Diphtheria	Blood Parasites: _____	QuantIFERON
Foodborne Pathogens (<i>B. cereus</i> , <i>C. perfringens</i> , <i>S. aureus</i>)	Country visited outside US: _____	OTHER TESTS FOR INFECTIOUS AGENTS
Gonorrhea Culture: Incubated? <input type="checkbox"/> yes <input type="checkbox"/> no	Ova & Parasites: Immigrant? <input type="checkbox"/> yes <input type="checkbox"/> no	Test name: _____
Hrs. incubated: ____ Add'l specimen codes: ____	Cryptosporidium	Prior arrangements have been made with the following DHMH Laboratories Administration employee: _____
MRSA (rule out)	Cyclospora/Isospora	
VRE (rule out)	Microsporidium	
ENTERIC INFECTIONS	Pinworm	
Campylobacter	VIRUS ISOLATION/CHLAMYDIA	
<i>E. coli</i> 0157 typing/Shiga toxins	Adenovirus*	SPECIMEN SOURCE CODE: PLACE CODE IN BOX NEXT TO TEST
Enteric Culture - Routine (Salmonella, Shigella, <i>E. coli</i> 0157, Campylobacter)	<i>Chlamydia trachomatis</i> culture	B Blood
Salmonella typing	Cytomegalovirus (CMV)	BW Bronchial Washing
Shigella typing	Enterovirus (Inc. Echo & Coxsackie)	CSF Cerebrospinal Fluid
<i>Vibrio</i>	Herpes Simplex Virus (Types 1 & 2)	CX Cervix/Endocervix
Yersinia	Influenza (Types A & B)* Rapid Flu Test: Type _____	E Eye
REFERENCE MICROBIOLOGY	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	F Feces
ABC'S (BIDS) # _____	Patient admitted to hospital? <input type="checkbox"/> yes <input type="checkbox"/> no	N Nasopharynx/Nasal
Organism: _____	Parainfluenza (Types 1, 2, & 3)*	P Penis
Bacteria Referred Culture for ID	Respiratory Syncytial Virus (RSV)*	R Rectum
Specify: _____	Varicella (VZV)	SP Sputum
	* MAY INCLUDE RESPIRATORY SCREENING PANEL	T Throat
	Comments: _____	URE Urethra
		UFV Urine (First Void)
		UCC Urine (Clean Catch)
		V Vagina
		W Wound
		O Other: _____